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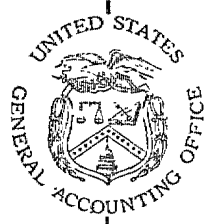

REVIEW OF MEDICARE COST REIMBURSEMENTS TO HOSPITALS BY THE GEORGIA HOSPITAL SERVICE ASSOCIATION, INC.

Social Security Administration
Department of Health, Education,
and Welfare

UNITED STATES
GENERAL ACCOUNTING OFFICE
Atlanta Regional Office

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March 18, 1971
(Date)

UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
ROOM 204, 161 PEACHTREE STREET, N.E.
ATLANTA, GEORGIA 30303

GAO 00305

March 18, 1971

Mr. Douglass M. Richard
Regional Representative, Bureau of Health Insurance
Social Security Administration
Department of Health, Education, and Welfare
50 Seventh Street, N.E., Room 404
Atlanta, Georgia 30323

DLG 05618

Dear Mr. Richard:

Herewith is a report on our review of Medicare cost reimbursements to hospitals by the Georgia Hospital Service Association, Inc. (Georgia Blue Cross). The purpose of our review was to examine the practices and procedures followed by Georgia Blue Cross in making cost settlements with hospitals. Our review was made at the offices of Georgia Blue Cross in Columbus, Georgia, and selected hospitals in the State of Georgia for which Georgia Blue Cross acted as the fiscal intermediary. We also performed a limited amount of work at the Georgia State Department of Family and Children Services in Atlanta, Georgia.

DLG 05846

Our review of Medicare cost reports submitted by three hospitals, which had been audited by public accountants under a subcontract with Georgia Blue Cross, showed that:

--The hospitals charged certain unallowable costs to the Medicare program which resulted in a net overstatement of Medicare's share of the costs by $13,340. (See pp. 6 through 10.)

--The hospitals tended to overallocate costs to inpatient cost centers for which Medicare shares a greater percentage of allowable costs than it does for other cost centers. As a result, Medicare's share of the costs was overstated by $22,300. (See pp. 10 through 17.)

--Hospitals and intermediaries used incomplete and erroneous data in computing cost settlements. As a result Medicare's share of costs was overstated by $46,510. (See pp. 17 through 20.)

--The hospitals' Medicare billings for services of hospital-based physicians exceeded reimbursable costs for such services by about $72,950 because excessive professional component percentages were used to compute that portion of total hospital charges applicable to professional services of the physicians. (See pp. 21 through 25.)

Our review of Georgia Blue Cross settlements with Medicare providers disclosed that errors were made for various reasons in computing settlements with 21 hospitals. As a result, 11 hospitals were overpaid a total of $45,100 and 10 hospitals were underpaid a total of $510. (See p. 26)

We noted also that 1967 Medicare payments to six hospitals serviced by Georgia Blue Cross included $4,250 for bad debts which should have been paid by the Georgia Old Age Assistance program. (See p. 27)

We recommend that consideration be given to (1) adjusting the hospitals' Medicare cost reports, where appropriate; (2) seeking recoveries accordingly; and (3) making changes in audit procedures where necessary. Because excessive reimbursements for the services of hospital-based physicians were noted in connection with all three cost reports included in our review, we are also recommending that all Georgia Blue Cross settlements with hospitals be re-examined to determine whether similar excessive reimbursements have occurred. Such re-examinations should be undertaken with a view toward taking recovery action, where appropriate.

Copies of this report may be made available to the Blue Cross Association (BCA), Georgia Blue Cross, and the three hospitals.

We would appreciate being advised of any action taken by the Social Security Administration, BCA, and Georgia Blue Cross regarding the matters discussed in this report.

Very truly yours,

R. J. Madison

Regional Manager

Enclosure

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ABBREVIATIONS

HEW	Department of Health, Education, and Welfare
BCA	Blue Cross Association
SSA	Social Security Administration
EKG	Electrocardiogram

CHAPTER 1

INTRODUCTION

The General Accounting Office has made a review of Medicare cost reimbursements to hospitals by the Georgia Hospital Service Association, Inc. (Georgia Blue Cross), a Medicare fiscal intermediary servicing about 100 hospitals in Georgia.

The Secretary of the Department of Health, Education, and Welfare (HEW) contracted with the Blue Cross Association (BCA) to carry out certain functions under the Medicare program. The contract is administered by the Social Security Administration (SSA). Georgia Blue Cross has been operating under a subcontract with BCA to make payments to providers of service under the Medicare program.

Our review was made primarily at the offices of Georgia Blue Cross in Columbus, Georgia; The Macon Hospital in Macon, Georgia; the Medical Center in Columbus, Georgia; and the Memorial Medical Center in Savannah, Georgia. The cost reports we reviewed covered 12-month reporting periods ending December 31, 1967, for The Macon Hospital and the Medical Center, and ending December 31, 1968, for the Memorial Medical Center. In addition, a limited amount of work was performed at the Georgia State Department of Family and Children Services in Atlanta, Georgia.

The hospitals' cost reports were audited by a public accounting firm under a subcontract with Georgia Blue Cross. The purpose of the audits was to provide a basis for making settlements of the payments due the hospitals for the reasonable costs of providing covered services to Medicare beneficiaries.

The following schedule summarizes the Medicare program costs claimed by the hospitals and those allowed by the intermediary on the basis of the audits.

Hospital	Medicare costs claimed	Intermediary audit adjustments	Medicare costs allowed
The Macon Hospital	$1,437,618	-0-	$1,437,618
Medical Center	1,072,786	$ 9,913	1,082,699
Memorial Medical Center	1,457,014	(35,430)	1,421,584
Totals	$3,967,418	$(25,517)	$3,941,901

CHAPTER 2

FEATURES OF MEDICARE PROGRAM PERTINENT TO THE SETTLEMENT PROCESS

The Medicare program was established by the Social Security Amendments of 1965 (42 U.S.C. 1395-1395 11). This program which became effective on July 1, 1966, provides two basic forms of protection against the costs of health care for eligible persons aged 65 and over.

One form, designated as Hospital Insurance Benefits for the Aged (part A), which is the principal subject of this report, covers inpatient hospital services and post-hospital care in extended care facilities, and in the patient's home.

The second form of protection, designated as the Supplementary Medical Insurance Benefits for the Aged Program (part B), is a voluntary program, and covers physicians' services and a number of other medical and health benefits, including outpatient hospital services and certain home care.

USE OF INTERMEDIARIES TO ADMINISTER PART A

Section 1816 (a) of the Social Security Act authorized the Secretary of HEW to enter into agreements with public and private organizations and agencies which have been nominated by the providers to act as fiscal intermediaries in the administration of benefits under part A.

Among other things, these fiscal intermediaries are responsible for (1) making payments at least monthly on an estimated basis to providers for covered services furnished Medicare beneficiaries; (2) furnishing consultative services to providers to enable them to develop accounting and cost-finding procedures which will insure providers equitable payment under the program; (3) communicating to providers any information or instructions furnished by the Secretary of HEW and to serve as a channel of communication from providers to the Secretary; (4) making such audits of the records of the providers as may be necessary; and (5) on the basis of such audits, making final determinations, on an annual basis, of the amounts of payments to be made.

USE OF CARRIERS TO ADMINISTER PART B

Section 1842 (a) of the Social Security Act authorized the Secretary of HEW to enter into contracts with public and private

organizations and agencies to act as "carriers" in the administration of benefits under part B.

Among other things, these carriers are responsible for making determinations of the rates and amounts of payments for physicians' services on the basis of reasonable charges.

METHOD OF PAYMENT TO PROVIDERS OF SERVICE

According to section 1814 (b) of the Social Security Act, payments to providers of service are to be made for the "reasonable cost" of services furnished to Medicare beneficiaries as determined under section 1861 (v) of the same law. Section 1861 (v) authorizes the Secretary of HEW to prescribe regulations establishing the method or methods of payment to be used and further states that such regulations should provide for making suitable retroactive corrective adjustments where, for a provider of services for any accounting period, the aggregate reimbursement proves to be either inadequate or excessive.

In carrying out these requirements, SSA issued regulations entitled "Principles of Reimbursement for Provider Costs" which established guidelines and procedures to be used by providers of service and fiscal intermediaries in determining reasonable cost. SSA intended that these reimbursement principles would recognize all necessary and proper costs incurred by providers in furnishing services to Medicare patients and would avoid absorbing any costs of providing care to non-Medicare patients.

Interim payments on an estimated cost basis are made to providers during the year. These payments are intended to approximate as nearly as possible the actual costs in order to minimize the amounts of adjustments at the time of final settlement.

To facilitate making settlements, providers are required to submit annual cost reports covering a 12-month period of operation. During the first year of the program, the provider had the option of submitting a report covering the period July 1, 1966, to the end of its accounting year if such report covered at least 6 months.

A provider may select any 12-month period for Medicare cost-reporting purposes regardless of the reporting year it otherwise uses. Cost reports are required to be submitted to the intermediary within 90 days after the end of the provider's reporting period.

PREPARATION OF MEDICARE COST REPORT

The principal document used in the settlement process is the Medicare cost report. This report was developed by SSA in consultation

with provider and intermediary groups and was designed to show what portion of a provider's total allowable costs was applicable to covered services.

Although the SSA principles of reimbursement offer providers several alternatives in arriving at the amount to be reimbursed, preparation of a cost report essentially consists of four steps:

1. Determination of allowable costs

   Under the SSA principles of reimbursement, direct and indirect costs which are reasonable and necessary for providing patient care are allowable. Certain specific costs, however, are unallowable and must be excluded for reimbursement purposes. These unallowable costs include (1) amounts attributable to physicians' care to individual patients which are reimbursable under part B; (2) bad debts applicable to non-Medicare patients; (3) fund-raising expenses; (4) costs of activities unrelated to patient care, such as cafeterias and gift shops; and (5) costs of personal convenience items, such as telephone, radio, and television services.

2. Allocation of allowable costs to revenue-producing activities

   After a provider has determined its total allowable costs for Medicare reimbursement purposes, the second step in the preparation of the cost report is to allocate these costs to those activities or services for which the hospital makes charges. This process, which is commonly referred to as "cost finding", involves the allocation of the costs of nonrevenue-producing activities or departments (such as administration, laundry, and housekeeping) to those activities or departments which produce revenue (such as operating rooms, pharmacies, laboratories, and routine daily services).

3. Apportionment of allowable costs between Medicare and non-Medicare patients

   After the provider has allocated its allowable costs to its revenue-producing activities, the third step in the preparation of the cost report is to apportion these costs to the Medicare program on the basis of charges applicable to Medicare patients. For example, if 40 percent of the charges of a hospital's X-ray department was applicable to the X-ray services provided to Medicare beneficiaries, then 40 percent of the allowable costs allocated to the X-ray department would be apportioned to the Medicare program for reimbursement purposes. Although the SSA principles of

reimbursement offer a number of alternatives in making such apportionments, the use of charges as the basis for apportioning costs represents a principal feature of the methods of reimbursement under the Medicare program.

4. Consideration of amounts paid or payable by beneficiaries and interim-payments received or due from the intermediary

After the provider has apportioned its allowable costs to the Medicare program, it must then consider deductible and coinsurance amounts payable by Medicare patients and interim-payments due from the intermediary for services provided to Medicare patients during the provider's reporting period. The difference between allowable costs and the sum of the payments received or due from patients and the intermediary represents the amount of final adjustment due to or from the program.

CHAPTER 3

DEFICIENCIES IN PREPARING MEDICARE COST REPORTS

We found that deficiencies in preparing Medicare cost reports resulted in both overstatements and understatements of amounts reimbursed by the program.

The net overstatement of Medicare costs amounted to about $82,150 ($230 at The Macon Hospital, $1,080 at the Medical Center, and $80,840 at the Memorial Medical Center). The overstatement occurred because (1) the hospitals charged certain unallowable costs to the Medicare program, (2) the hospitals overallocated costs to inpatient centers for which Medicare shares a greater percentage of allowable costs than it does for other cost centers, and (3) the hospitals used data in computing settlements which was incomplete and contained errors.

The overstatements and understatements of Medicare's share of hospital costs resulted in part because the hospitals, the auditors, and Georgia Blue Cross did not adhere closely to SSA's principles of reimbursement and related instructions on the preparation and audit of cost reports and settlement of reimbursable costs.

OVERSTATEMENTS AND UNDERSTATEMENTS OF ALLOWABLE COSTS

The three hospitals covered by our review charged certain unallowable costs to the Medicare program. In addition, certain allowable costs had been omitted from the costs charged to the Medicare program. The net overstatement of costs claimed by the three hospitals amounted to about $13,340. A summary of the costs we questioned and their estimated net effect on Medicare's share of hospital costs is shown below.

	Net overstatement (understatement) of Medicare Costs			
Nature of costs questioned	Total	The Macon Hospital	Medical Center	Memorial Medical Center
Part B professional component for hospital-based physician services included in Medicare costs under part A	$14,550			$14,550

Nature of costs questioned	Net overstatement (understatement) of Medicare Costs			
	Total	The Macon Hospital	Medical Center	Memorial Medical Center
Interest on current debt not offset by advance payments from Medicare	4,540	$1,310	$160	3,070
Interest on bonded debt not offset by interest income	3,600			3,600
Discount on drugs sold to employees	2,040			2,040
Bad debts	500	500		
Research costs	210			210
Interest on hospital bonded debt paid by the city not claimed as an allowable cost	(11,020)	(11,020)		
Depreciation expense understated	(1,080)	(1,080)		
Net effect on Medicare costs	$13,340	($10,290)	$160	$23,470

Part B professional component for hospital-based physicians included in part A costs

The Memorial Medical Center's 1968 cost report included $14,550 in costs charged to part A of the Medicare program for salaries paid in 1966, 1967, and 1968 which the hospital had previously identified as being applicable to the professional services of physicians to individual patients.

Under part A of the Medicare program, hospital costs for the professional (part B) component of the salaries for the services of hospital-based physicians to individual patients should be excluded from allowable costs.

The Memorial Medical Center's 1966 and 1967 cost reports excluded from allowable costs about $6,250 and $22,500, respectively, for the professional (part B) component portion of the salaries of certain staff physicians. Medicare's share of these excluded costs was about $650 and $4,600, respectively. In March 1969, the hospital submitted statements to the intermediary which were signed by the hospital administrator and by certain staff physicians in the rehabilitation,

medical education, psychiatry, surgery education, and pediatrics departments. These statements showed that from 5 to 40 percent of the physicians' salaries were applicable to part B services.

In June 1969, the Memorial Medical Center submitted its 1968 Medicare cost report which included the $650 and $4,600 for Medicare's share of part B costs previously excluded from the 1966 and 1967 cost reports. The hospital also included in its 1968 part A costs $9,300 which represented Medicare's share of the part B professional component of salary costs paid to hospital-based physicians.

The hospital comptroller advised us that the claim for reimbursement under part A was made because the hospital had not billed the part B carrier for professional services administered by these specific physicians to Medicare patients. He stated that the hospital officials were of the opinion that the costs of the services could be collected under part A of the program because charges for these services had not been billed to and collected from the part B carrier.

We were informed, however, by a number of these physicians that they had billed part B of Medicare, as well as Medicaid, private insurers, and individual patients for their professional services to inpatients and outpatients. Further, we noted that the hospital's employment contracts with certain of these physicians provided for payment to the hospital of physicians' professional fees in excess of specified amounts.

Under these circumstances, we believe that, if the hospital wants to recover the previously agreed-upon portion of the physicians' compensation applicable to their professional services to individual patients, such recoveries should be made from the physicians who had billed for the services rather than from retroactive charges to part A of the Medicare program.

Interest on current debt not offset by advance payments from Medicare

The three hospitals included interest expense on current indebtedness in allowable hospital costs. The interest expense was overstated because Medicare current financing (advance) payments to the hospitals were not considered in the determination of allowable interest expense claimed on working capital loans as required by Intermediary Letter No. 62 dated June 21, 1966, and by the Provider Reimbursement Manual.

According to our computations, interest expense on current indebtedness claimed by the hospitals should have been reduced by $21,390 with a resultant reduction of $4,540 in Medicare's share of hospital costs as shown on the following page.

Hospital	Reduction in total allowable costs	Reduction in Medicare costs
The Macon Hospital	$ 6,290	$1,310
Medical Center	790	160
Memorial Medical Center	14,310	3,070
Total	$21,390	$4,540

Interest on bonded debt not offset by interest income

Interest expense totaling $96,900 on long-term bonded debt claimed by the Memorial Medical Center should have been offset by $16,800 of interest income earned by the bond sinking fund. The reduction in allowable interest expense would reduce Medicare's share of hospital costs by $3,600. This matter was discussed with the Hospital Accounting Branch Chief, Bureau of Health Insurance, SSA, who agreed that interest income earned on sinking fund deposits should be used to offset interest expense on the bonded debt.

Discounts on drugs sold to employees

The Memorial Medical Center sold drugs to hospital employees at discounted prices which were greater than the costs of the drugs but were lower than the prices charged to hospital patients. The amounts of the discounts were then allocated to the administrative and general expense account, a portion of which was charged to the Medicare program.

In our opinion, the amount of the drug discount should not be an allowable expense because the discounted prices exceeded the drug costs. We are also of the opinion that the sale of drugs to employees should have been considered as nonpatient care transactions and the sales revenue should have been treated as a reduction to allowable costs.

The treatment of drug discounts as an allowable expense to be allocated to the Medicare program had several offsetting effects on the calculation of the Medicare reimbursement; however, the net effect was to increase the costs charged to the Medicare program by $2,040.

Bad debts

The Macon Hospital overstated reimbursable costs by about $500 for bad debts. These costs were overstated because: (1) the hospital claimed $428 in bad debts for professional services by hospital-based physicians, (2) the hospital claimed $46 in bad debts which were not eligible for reimbursement because they related to charges for services not covered by Medicare, and (3) the hospital was reimbursed $44 for a $22 bad debt because of a duplicate claim.

Research costs

The Memorial Medical Center overstated Medicare's share of hospital costs by $210 because it considered $995 in costs applicable to a laboratory where dogs were used in experiments to be a part of costs attributable to usual patient care. These costs consisted of $90 for the installation of a water meter in the existing laboratory and $905 for architects' fees and bidding documents for a proposed new facility.

Section 500 of the Provider Reimbursement Manual states that costs incurred for research purposes, over and above usual patient care, are not includable as allowable costs. In our opinion, costs associated with the experimental dog laboratory were not attributable to usual patient care.

Interest on hospital bonded debt paid by the city not claimed as an allowable cost

The Macon Hospital which is owned by the city of Macon did not include in its 1967 cost report interest expense paid by the city on certain hospital construction bonds. We believe that the expense was allowable under SSA's principles of reimbursement. Medicare's share of interest expense on the bonds was $11,020. A hospital official informed us that an amended claim would be submitted for Medicare's share of this interest expense.

Depreciation expense understated

During our review, The Macon Hospital personnel discovered that depreciation expense on the hospital's 1967 cost report was understated by $5,190. As a result, Medicare's share of the hospital's costs was understated by $1,080. The understatement of depreciation expense resulted because only one-half year of depreciation expense was claimed on equipment which was owned for a full year. Hospital officials informed us that they planned to submit an amended claim for Medicare's share of the understated depreciation expense.

OVERALLOCATION OF HOSPITAL COSTS TO INPATIENT COST CENTERS

We found that, in allocating hospital costs to the various revenue-producing activities, there was a tendency to overallocate costs to inpatient cost centers. The Medicare program shares a greater percentage of allowable inpatient costs than it does for other cost centers. This practice resulted in a net overstatement of about $22,300 in costs to be reimbursed to the three hospitals included in our review.

Overallocation of hospital expenses
to inpatient costs at The Macon Hospital

The Macon Hospital used the combination method (estimated percentage basis) to apportion allowable costs to Medicare and non-Medicare patients. Under this method, hospital costs were to be allocated between inpatient and outpatient services on logical bases. The inpatient expenses were then to be allocated between routine inpatient expenses and special service (ancillary) inpatient expenses on the basis of percentages agreed to by the intermediary.

For 1967, about 24 percent of The Macon Hospital's routine inpatient costs, about 22 percent of its inpatient ancillary costs and about 2 percent of its outpatient costs were apportioned to the Medicare program. Therefore, any overallocation of hospital costs to inpatient services resulted in increases in costs charged to the Medicare program.

The net overstatement of hospital costs to be reimbursed by the Medicare program amounted to $10,160, because certain costs were overallocated to inpatient services. A summary of the costs we questioned and their estimated net effect on the Medicare reimbursement is shown below.

Type of hospital cost	Net overstatement of Medicare Reimbursement
Plant operation and depreciation	$6,710
Housekeeping	1,590
Medical records and library	990
Ambulance service and related costs	450
Laundry service	420
Total	$10,160

Plant operation and depreciation

The hospital plant operation and depreciation expenses were allocated between inpatient and outpatient services based on the square footage of space used in providing these services. In determining the number of square feet allocable to outpatient services, the emergency room and the outpatient clinics were considered entirely applicable to outpatient services. However, the square footage of those departments which provided both inpatient and out-

patient services was allocated entirely to inpatient services. Although this was partially offset because consideration was not given to the inpatient services provided by the emergency room and outpatient clinics, we believe that 14,038 additional square feet should have been allocated to outpatient services.

Had the additional square feet been allocated to outpatient services, the percentage used to allocate plant operation and depreciation expenses to outpatient services would have been 9 percent instead of 4 percent and an additional $15,580 of plant operation expenses and $17,400 of depreciation expenses would have been allocated to outpatient services. Had the 9-percent factor been used, the costs reimbursable by the Medicare program would have been reduced by $3,170 for plant operation and by $3,540 for depreciation, or a total of $6,710.

Housekeeping

Housekeeping department costs were allocated between inpatient and outpatient services on the basis of the number of hours employees were assigned to work in a particular department for the year. In determining the number of hours allocable to outpatient services, only the assigned hours applicable to the outpatient clinics were used. The hours that housekeeping personnel were assigned to other departments which provided both inpatient and outpatient services were allocated entirely to inpatient services. Similarly, the hours applicable to inpatient services provided in the outpatient clinics were allocated entirely to outpatient services. On the basis of available records showing the percent of time employees in each department spent on outpatient services, we believe that the number of hours allocated to outpatient services was understated by about 4,000 hours.

Had the additional hours been allocated to outpatient activities, the percentage used to allocate housekeeping department costs would have been about 7 percent instead of the 4 percent used in the cost report. By using the higher percentage, $19,060 rather than $11,260 would be classified as outpatient costs, a difference of $7,800. Had the $7,800 been considered as outpatient rather than as inpatient costs, the costs charged to the Medicare program would have been reduced by $1,590.

Medical records
and library

On the basis of an arbitrary estimate, the hospital allocated 95 percent of medical records and library expenses to inpatient services and 5 percent to outpatient services.

Information we obtained during our review showed that three full-time employees devoted their entire time working on outpatient

records. These employees' time represented 9 percent of all time spent working on medical records and library activities. By using 9 percent instead of 5 percent, an additional $4,850 would be transferred from inpatient to outpatient costs, and the costs apportioned to Medicare would have been reduced by $990.

Ambulance service

In developing the cost report, the hospital's charges for ambulance services applicable to Medicare patients admitted to the hospital as inpatients were classified as outpatient charges. The charges for such services applicable to non-Medicare patients were classified as inpatient charges. The costs of the hospital's ambulance service were allocated between inpatient and outpatient services on the basis of these charges.

In our opinion, all ambulance service charges and related costs should have been allocated to outpatient services in order to be consistent with the Medicare Law and related regulations which provide that ambulance services are to be covered under the supplementary medical insurance (part B) portion of the Medicare program.

The inconsistent treatment of ambulance service charges applicable to Medicare and non-Medicare patients had several offsetting effects on the calculation of the Medicare reimbursement; however, the net effect was to increase by $450, the costs charged to the Medicare program.

Laundry service

Laundry department costs were allocated between inpatient and outpatient on the basis of pounds of laundry processed. In determining the pounds of laundry processed which were allocable to outpatient services, the hospital included only the laundry processed for the outpatient clinics and the emergency room. The weight of laundry processed for other departments which provided both inpatient and outpatient services was allocated entirely to inpatient services.

Hospital records of laundry processed for the various departments during 1967 had been destroyed. However, on the basis of our analysis of laundry records for the first 11 months of 1969, it appears that Medicare's share of the 1967 hospital costs was overstated by as much as $420.

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Georgia Blue Cross officials and their auditors advised us that, in their opinion, our findings relating to The Macon Hospital involved

the use of methods for allocating costs between inpatient and outpatient services which were more sophisticated than SSA's principles of reimbursement and related instructions had intended. We believe, however, that, when hospital statistical data is readily available for use in making more accurate cost allocations, the data should be considered in connection with the preparation and intermediary audits of Medicare cost reports.

Overallocation of hospital expenses to inpatient costs at the Medical Center and the Memorial Medical Center

The Medical Center and the Memorial Medical Center used the combination method (with cost finding) to apportion allowable costs between Medicare and non-Medicare patients.

Our review of the Medical Center's cost report for 1967 showed that the Medicare program absorbed about 23 percent of the hospital's routine inpatient costs, about 19 percent of its special service inpatient costs, about 8 percent of its outpatient costs, no nursery costs; and no costs applicable to concession areas. Our review of the Memorial Medical Center's cost report for 1968 showed that the Medicare program absorbed about 25 percent of the hospital's inpatient routine costs, 24 percent of its inpatient special service costs, and 10 percent of its outpatient costs. The program absorbed no costs applicable to the nursery, nursing home, and concession areas. Consequently, any overallocation of hospital costs to inpatient services resulted in the apportionment of increased costs to the Medicare program.

The net overstatement of hospital costs charged to the Medicare program amounted to $12,140 because the costs were overallocated to inpatient services. A summary of the costs we questioned and their estimated net effect on the Medicare reimbursement is shown below.

Net overstatement of Medicare reimbursement

Type of hospital cost	Total	Medical Center	Memorial Medical Center
Nursing administration	$ 5,610	$ 910	$4,700
Dietary and supplies	2,270	2,270	-0-
General service	1,760	1,530	230
Medical records	1,100	-0-	1,100
Laundry service	730	-0-	730
Pharmacy	670	-0-	670
Total	$12,140	$4,710	$7,430

Nursing administration

Medicare's share of nursing administration costs at the two hospitals was overstated by $5,610 because all nursing administration costs were allocated to routine inpatient services, thereby understating nursing costs to other cost centers where either no costs were apportioned to the Medicare program, or where the program's share of the costs was lower than its share of inpatient routine service costs.

A statistical basis available at the time of our review for allocating nursing administration costs was the daily average number of nurses employed at the hospitals during the year in each cost center where nurses were assigned for duty. This distribution of nursing time is summarized below:

	Daily average number of nurses assigned	
Cost center	Medical Center	Memorial Medical Center
Medical supplies and expense	15	21
Operating and recovery rooms	46	28
Delivery rooms	14	7
Inpatient routine services	370	245
Nursery	21	18
Outpatient clinics	14	22
Emergency rooms	16	20
Nursing home	0	25
Total	496	386

If the allocation of nursing administration costs had been made on the basis of the daily average number of nurses assigned, as shown above, the costs charged to the Medicare program would have been reduced by $910 at the Medical Center and by $4,700 at the Memorial Medical Center.

Dietary and supplies

At the Medical Center, we identified $10,130 in dietary expenses, supplies, and other expenses which were included in the allowable costs apportioned to the Medicare program which should have been allocated to the nursery. Because none of the costs allocated to the nursery was apportioned to the Medicare program, the total amount of expenses shared in by the program was overstated.

Had the $10,130 been allocated to the nursery, the costs charged to the Medicare program would have been reduced by $2,270.

General service

Costs apportioned to the Medicare program by the Medical Center and the Memorial Medical Center were overstated by $1,760 because general service expenses (depreciation, administrative and general, operation of plant, and housekeeping) were not equitably allocated to gift shops and other areas used by volunteer workers.

Because the hospitals did not receive any income from the operation of gift shops and other concession areas, reimbursable costs were not reduced by the income from these operations. In December 1967, SSA instructed its intermediaries that, under the foregoing circumstances, general service expenses should be allocated to gift shops and must be excluded in determining the costs to be charged to the Medicare program.

Medical records

Medical records costs at the Memorial Medical Center were allocated to other cost centers on the basis of estimates of employees' time spent maintaining the records. We noted, however, that all medical records costs applicable to the nursery, an ineligible cost center, had been allocated to inpatient routine services. We also noted that the costs allocated to the emergency room had been understated.

The percentages of time spent in maintaining medical records shown in the cost report and the revised percentages which we obtained are shown below.

Cost center	Cost report percentages	Revised percentages
Inpatient routine services	92	86.5
Emergency room	5	6.0
Nursery	0	4.5
Nursing home	3	3.0
Total	100	100.0

Had medical records costs been allocated to cost centers using the more accurate estimates of the time expended, the costs charged to the Medicare program would have been reduced by $1,100.

Laundry services

Memorial Medical Center's 1968 laundry costs were allocated to the various hospital cost centers on the basis of estimated weight of laundry processed.

Hospital records for laundry actually processed for the various departments in 1968 were not available. However, on the basis of our analysis of statistics gathered for 1969, it appeared that Medicare's share of hospital costs for 1968 was overstated by as much as $730 because inaccurate estimates were used to allocate laundry costs to the various hospital cost centers.

Pharmacy

Memorial Medical Center's pharmacy expenses were to be allocated to other cost centers in proportion to the cost of drugs issued to the centers for general hospital use or sold to patients. In making the allocation, the hospital (1) established the total cost of drugs issued for hospital use or sold to patients, (2) determined the cost of drugs issued to the various departments for hospital use, and (3) considered the difference between these two costs as the cost of drugs sold to patients.

We observed that the hospital made errors in each of the above three categories. In the first, the total cost was not limited to the cost of drugs issued for hospital use or sold to patients but included cost of drugs sold to employees, salaries, supplies and other expenses, and about $75,000 in costs which had been allocated to the pharmacy from other cost centers. In the second, the cost of drugs issued to the operating rooms, anesthesia, X-ray, laboratory, outpatient, and emergency room cost centers was not included. Also, the cost of drugs issued to the inpatient routine services cost center was understated. In the third, the cost of drugs sold to patients was overstated because of the erroneous data developed in the first two categories.

Had correct statistical bases been used in the allocation of pharmacy expenses, costs charged to the Medicare program would have been reduced by $670.

INCOMPLETE OR ERRONEOUS DATA USED IN COMPUTING HOSPITAL REIMBURSEMENT SETTLEMENTS

Our review showed that data used in computing cost settlements for the three hospitals included in our review was incomplete or contained errors. The incomplete and erroneous data used to compute hospital reimbursement settlements resulted in a net overstatement of about $46,510 in reimbursable costs due the hospitals from the Medicare program.

The estimated net effect that the incomplete and erroneous data had on Medicare reimbursements is shown on the following page.

Item	Net overstatement (understatement) of Medicare Costs			
	Total	The Macon Hospital	Medical Center	Memorial Medical Center
Computer errors	$40,040	$ -0-	$ -0-	$40,040
Understatement of data used in cost settlement process	7,330	1,200	-0-	6,130
Failure of the intermediary's auditors to make all adjustments	9,870	-0-	2,110	7,760
Overstatement of patient liability for part A diagnostic deductible	(10,270)	(840)	(5,900)	(3,530)
Overstatement of part B payments received	(460)	-0-	-0-	(460)
Net effect on Medicare costs	$46,510	$ 360	($3,790)	$49,940

Computer errors

Medicare costs claimed by the Memorial Medical Center were overstated by $40,040 because of errors in data used in the calculation of the program's share of total costs.

Because of a probable computer error, Medicare charges were overstated for four outpatients by a total of $20,000. As a result, the Medicare program's share of outpatient costs was overstated by $13,480.

Because of another computer error, outpatient deductibles were understated by $33,200. This error occurred because deductible amounts frequently were not printed in the proper column in the computer printout. As a result, the patients' contributions to reimbursable costs were understated. The net effect was a $26,560 overstatement of Medicare costs.

Georgia Blue Cross officials stated that action is being taken to prevent errors and omissions in computer printouts used in the calculation of reimbursement settlements.

Understatement of data used in settlement process

Certain data pertaining to Medicare patients used in cost settlement computations for The Macon Hospital and the Memorial Medical Center

was understated. The understated data included (1) the amount of interim payments received, (2) the amount of deductibles and coinsurance payable, (3) covered charges, and (4) inpatient days. As a result, the amount due from the Medicare program was overstated by $1,200 for The Macon Hospital and by $6,130 for the Memorial Medical Center.

The data used by the hospitals was taken from Georgia Blue Cross computer printouts which were dated about 3 months after the end of the hospitals' reporting periods. The data shown on the computer printouts, however, was not adjusted to include transactions occurring after the date of the printouts which were applicable to the reporting periods covered by the cost reports.

Since we found that pertinent data had not been considered in the reimbursement calculation for two of the three hospitals, it is probable that similar omissions existed in data used in the computations of Medicare payments to other hospitals. Further, under procedures which were in effect at the time of our review, the omitted data would not have been considered in the computation of costs reimbursable by the Medicare program for subsequent years.

Georgia Blue Cross officials advised us that corrective action is being taken to assure that appropriate consideration is given to all pertinent data in reimbursement calculations.

Failure of intermediary's auditors to make all adjustments

Costs reimbursable to two of the three hospitals included in our review were overstated by $9,870 because required adjustments to cost statements noted in working papers prepared by the public accounting firm were not included in recommended adjustments furnished to the hospitals for incorporation into revised statements. We were informed that adjustments apparently were not included because of an oversight by the public accountants.

	Overstatement (understatement) of Medicare costs		
Adjustment	Total	Memorial Medical Center	Medical Center
Overstatement of Medicare special service charges	$7,760	$7,760	
Understatement of Medicare special service charges	(120)		(120)

Adjustment	Overstatement (understatement) of Medicare costs		
	Total	Memorial Medical Center	Medical Center
Understatement of interim payments received from Georgia Blue Cross	$1,760		$1,760
Overstatement of Medicare deductible and coinsurance	470		470
Net effect on Medicare costs	$9,870	$7,760	$2,110

Overstatement of patient liability for part A diagnostic deductible

Costs reimbursable to the three hospitals were understated a total of $10,270 because deductibles billed to part A Medicare patients were overstated. Until April 1968, the Medicare law provided that outpatient hospital services which were diagnostic in nature were covered under part A. Those outpatient services which were therapeutic in nature were covered under part B. The part A diagnostic services were subject to a $20 deductible and a 20-percent coinsurance for expenses above the deductible. Part B therapeutic services were subject to a $50 deductible and a 20-percent coinsurance for expenses above the deductible; however, the $20 diagnostic part A deductible was considered as a covered expense under part B and could be applied to the part B $50 deductible or reimbursed subject to the 20-percent coinsurance.

All outpatient part A diagnostic deductibles were classified as received or receivable from patients; however, some of these deductibles were treated as reimbursable expenses under part B which should have reduced the patients' liabilities for the part A deductibles. As a result, the deductible amounts shown as received or receivable from patients were overstated.

Overstatement of part B payments received

In making an adjustment to its cost report, the Memorial Medical Center overstated by $460 excess part B payments received for services of hospital-based physicians for the 9-month period ended December 31, 1968 (See p. 23). As a result, the amount reimbursable to the hospital was understated by $460.

CHAPTER 4

EXCESSIVE REIMBURSEMENT FOR PROFESSIONAL SERVICES OF HOSPITAL-BASED PHYSICIANS

The three hospitals included in our review charged part B of the Medicare program about $72,950 more than the hospitals' cost for services provided to Medicare patients by hospital-based radiologists and pathologists. These excess charges included the part B deductible and coinsurance amounts which should have been paid by Medicare patients. The excess charges occurred because the hospitals' charges to the part B carrier and Medicare patients exceeded their payments to the physicians for professional services performed for the patients. As a result, the three hospitals realized substantial windfalls or profits.

We do not believe that it is the intent of SSA's principles of reimbursement to permit hospitals to realize such profits in connection with the portion of their charges applicable to the professional services of hospital-based physicians (the part B professional component). Section 405.485 of the Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians provides that:

> "Once the portion of a physician's compensation attributable to professional services to supplementary medical insurance beneficiaries has been determined, a schedule of charges can be developed. To be deemed reasonable the charges should be designed to yield in the aggregate, as nearly as possible, an amount equal to such portion of his compensation.***"

According to SSA instructions, information supporting the established schedule of charges should be reviewed by both the intermediary and the carrier making part B payments. The intermediary is responsible for obtaining from the hospitals data supporting hospital-based physicians' compensation for professional services as reflected in the schedule of charges. The intermediary is also responsible for approval of the allocation of compensation between administrative services (part A) and professional services (part B). In so doing, the intermediary should review all of the information for completeness and reasonableness and then turn the information over to the carrier for use in determining the proper reimbursement for charges by physicians for their services.

Because neither the intermediary nor the part B carrier appeared to adequately fulfill their responsibilities in this regard, part B charges billed by the three hospitals were considerably more than Medicare's share of the professional component portion of the physicians' compensation paid by the hospitals as shown on the cost reports.

The excessive reimbursements at The Macon Hospital and the Medical Center pertain only to inpatient services by hospital-based physicians in 1967. We were unable to obtain sufficient data to enable us to estimate the excessive part B charges for outpatient services at these hospitals. The excessive part B charges by the Memorial Medical Center were for both inpatient and outpatient services in 1968.

THE MACON HOSPITAL

In 1967, The Macon Hospital billed part B and Medicare patients $26,540 for professional services rendered by its hospital-based pathologists. These charges were about $11,110 more than the amount paid by the hospital to the pathologists for the same services which had been deducted from costs reimbursed under part A.

The excess charges resulted because the 11.4 percent of hospital charges used to bill for the physicians' part B professional component applicable to laboratory and electrocardiogram (EKG) services was too high. In our opinion, this could have been determined at the time the percentage was initially established in July 1966 and should have been corrected at the time the 1967 cost report was audited in 1968.

In July 1966, in support of the 11.4 percent part B professional component percentage used to bill for laboratory and EKG services, the hospital advised Georgia Blue Cross that, for the 5-month period ended May 1966, a total of $50,330, or 60 percent of the $83,880 in fees the hospital paid to its pathologists during the period, was applicable to the physicians' professional services to patients. The $50,330 was 11.4 percent of the hospital's total laboratory and EKG charges of about $442,000. We found, however, that the hospital had actually paid the pathologists only $45,830 during the period. The amount paid included $43,780 for laboratory services and $2,050 for EKG services. Assuming that 60 percent of these payments was allocable to part B professional services rendered to patients, the part B professional component initially established in 1966 should have been about 6.5 percent for laboratory services and about 4.7 for EKG services, rather than 11.4 percent for both services.

In making adjustments to the hospital's 1967 cost report to deduct part B professional component costs from allowable costs reimbursable under part A, the hospital used rates which were equivalent to 6.5 percent of hospital charges for laboratory services and 4.7 percent of hospital charges for EKG services. Because the hospital billed Medicare for these services during 1967 at the rate of 11.4 percent of charges, the amounts deducted from the part A Medicare reimbursement, $15,430, was about $11,110 less than the $26,540 billed by the hospital for the pathologists' services.

MEDICAL CENTER

In 1967, the Medical Center billed part B and Medicare inpatients about $36,520 for the professional services of hospital-based pathologists.

These charges were about $16,110 more than the amount paid by the hospital to pathologists for the same services which had been deducted from costs reimbursed under part A.

The hospital charged part B for laboratory services at the rate of 20 percent of the hospital's charges. We were unable to obtain from either the hospital or Georgia Blue Cross computations or documentation to support the 20 percent rate used to bill part B; however, it was apparent from information available in 1966 that the percentage used to bill for the pathologists' services was excessive. The pathologists were compensated by the hospital on the basis of a guaranteed annual fee and a percentage of the net revenues of the hospital's Pathology Department. For the 6-month period ended December 31, 1966, the hospital's Medicare cost report showed that the pathologists' part B professional component was about 10.8 percent of laboratory charges as contrasted with the 20 percent used by the hospital to bill for part B services in 1967.

In the hospital's 1967 cost report, the deduction from the allowable costs reimbursable under part A for the pathologists' part B professional component applicable to all inpatients was $102,560, or about 11.2 percent of the hospital's charges. Medicare's share of this deduction was $20,420, or $16,100 less than the $36,520 in part B charges billed by the hospital for pathologists' services to Medicare inpatients.

In our opinion, the intermediary and the carrier should have obtained and evaluated sufficient data to assure that the part B professional component percentage being used was designed to yield to the hospital its approximate costs for the pathologists' services. In the absence of such assurance, we believe that Georgia Blue Cross should have adjusted the hospital's cost report to recapture that portion of part B billings which was in excess of the hospital's pathological costs.

MEMORIAL MEDICAL CENTER

The Memorial Medical Center billed part B and Medicare patients about $62,370 for professional services of hospital-based pathologists and radiologists during the first 3 months of 1968 for inpatient and outpatient services. These charges were $45,730 more than the hospital's payments to the physicians for the same services which had been deducted from the costs reimbursed under parts A and B.

The hospital's 1968 cost report was adjusted to offset the part B overpayment for services during the last 9 months of the year against the costs claimed on the cost report. The adjustment was made in accordance with instructions pertaining to those hospitals using the combined billing method which the Memorial Medical Center had elected to use. The combined billing method was authorized pursuant to the Social Security Amendments of 1967, which provided, effective April 1, 1968, a simplified method for reimbursing hospitals

for radiology and pathology services furnished by hospital-based physicians to inpatients. Under the simplified method, it was not necessary to break down the hospital's charges for services by these physicians, on a patient-by-patient basis, into the portions covered by part A and the physicians' professional component covered under part B.

Adjustments to the hospital's 1968 cost report were not made for overpayments applicable to part B services during the first 3 months of the year.

The excess payments occurred because part B billings by the hospital for the professional services of its radiologists and pathologists were significantly greater than the amount deducted by the hospital from its reimbursable costs for payments to the physicians for the same services. The following table compares the percentage of charges generally used to bill part B and the percentage of charges that were equivalent to the amounts that had been deducted from the hospital's inpatient and outpatient costs reimbursed under parts A and B.

Physicians	Professional component percentages used to bill part B	Professional component percentages applicable to amounts deducted from reimbursable costs	
		Inpatient	Outpatient
Pathologists	60	5	5
Radiologists	41	20	36

We were unable to obtain computations or documentation from either the hospital or Georgia Blue Cross to support the professional component percentages used to bill part B; however, it was apparent from data available in 1967 that the percentage used to bill for the pathologists' services was excessive.

Pathologists were compensated by the hospital on the basis of a formula which featured various percentages of gross laboratory charges and adjusted gross charges.[1] We noted that, for the 6-month period ended December 31, 1967, the hospital's payments to pathologists for both administrative (part A) and professional (part B) services amounted to about 21 percent of laboratory charges as contrasted with the 60 percent of charges generally used by the hospital during 1968 to bill for professional (part B) services only. We noted that the hospital later determined that, of the total compensation paid to pathologists, 81 percent was for administrative (part A) services and 19 percent was for professional (part B) services.

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[1] Adjusted gross charges excluded (a) the charges applicable to the services for which the pathologists were compensated on the basis of gross charges, (b) charges applicable to charity and welfare patients, (c) an allowance for administrative expenses and bad debts, and (d) departmental salaries and supplies.

Radiologists were compensated by the hospital at rates of 41 percent of adjusted gross charges[2] for inpatient services and 60 percent of adjusted gross charges for outpatient services. Although these rates approximated the 41 percent of gross charges used to bill for professional (part B) services, the hospital's 1968 cost report showed that only about 55 percent of the radiologists' compensation was allocable to part B services which was deducted from the hospital's costs reimbursed under parts A and B.

In our opinion, the intermediary and the carrier should have obtained and evaluated sufficient data to assure that the part B professional component percentages being used were designed to yield to the hospital its approximate costs for the services. In the absence of such assurance, we believe that Georgia Blue Cross should have adjusted the hospital's cost report to recapture that portion of part B billings which were in excess of the hospital's costs.

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We discussed the excessive reimbursements with the intermediary and with the intermediary's auditors. Georgia Blue Cross officials advised us that SSA instructions were not clear as to the intermediary's responsibilities concerning accuracy of the part B professional componet for hospital-based physicians. The auditors advised us that they were aware of the situations discussed in this chapter, but that they were only responsible for the accuracy of the hospitals' cost reports and had no responsibility to adjust excessive payments to the hospitals by the part B carrier.

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[2]Adjusted gross charges excluded (a) charges applicable to charity and welfare patients and (b) an allowance for bad debts.

CHAPTER 5

ERRONEOUS FINAL SETTLEMENTS AND IMPROPER HANDLING OF BAD DEBTS

During our review, we developed data in two other areas. The additional data revealed that (1) for a variety of reasons 11 hospitals were overpaid a total of $45,100 and 10 hospitals were underpaid a total of $510 by Georgia Blue Cross, and (2) about $4,250 for bad debts should have been paid by the Georgia Old Age Assistance program (OAA) rather than by the Medicare program.

FINAL SETTLEMENT PAYMENT ERRORS

During a period of almost 3 years after the inception of the Medicare program in July 1966, Georgia Blue Cross made final settlement overpayments totaling $45,100 to 11 hospitals and underpayments totaling $510 to 10 hospitals.

Overpayments were made because: (1) previous tentative settlements were not considered in computing final settlement amounts; (2) an erroneous amount was considered as the amount of a previous tentative payment; (3) final settlement payments to hospitals were made of amounts actually owed by the hospitals to the Medicare program; (4) a duplicate final settlement payment was made; (5) a final settlement amount due from a hospital for a long period of time had not been requested or received; and (6) an error was made in the calculation of an outpatient settlement amount.

The underpayments were made because: (1) the total amount of bad debts claimed by one hospital was erroneously considered as an amount due the Medicare program; and (2) errors were made in the calculation of outpatient settlement amounts.

The payment errors resulted from the absence of effective procedures to maintain adequate control over, and to assure the accurate computation of, tentative and final settlement adjustments.

We discussed the erroneous payments with Georgia Blue Cross officials and recommended that they investigate the need for instituting a system to control the determination of tentative and final settlement payments.

Georgia Blue Cross accepted our recommendation and instituted a system to control tentative and final settlement payments. Using the system, their personnel reviewed tentative and final settlement payments made on cost reports received through June 25, 1969, recovered $45,100 in overpayments, and issued checks to hospitals for $510 in underpayments for a net recovery of $44,590.

MEDICARE REIMBURSEMENT FOR BAD DEBTS WHICH SHOULD HAVE BEEN PAID BY THE GEORGIA OLD AGE ASSISTANCE PROGRAM

We examined into bad debts claimed on 1967 cost reports by six hospitals. As shown in the following schedule, we found that, of $25,040 in deductible and coinsurance bad debts claimed, $4,250 or about 17 percent, should have been paid by the Georgia Old Age Assistance program.

Hospital	Bad debts Claimed	Payable by OAA
The Macon Hospital	$11,540	$1,720
Medical Center	4,010	1,270
University Hospital	6,080	1,000
City-County Hospital	1,500	40
Memorial Hospital - Waycross	1,020	60
Pineview General	890	160
Total	$25,040	$4,250

Although we recognize that in Georgia about 80 percent of funds paid by the State Old Age Assistance program was furnished by the Federal Government, we believe that deductible and coinsurance amounts which are the responsibility of the State program should not be charged to and paid by the Medicare health insurance program. We believe there is a need for improved audit procedures -- such as screening hospital admissions or screening patients not paying their deductible and coinsurance amounts -- which would enable the intermediary and the hospitals to identify those patients who are eligible to have their Medicare deductible and coinsurance amounts paid by the State.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

For the three hospitals included in our detailed review, it is our opinion that the SSA principles of reimbursement and related instructions were not always closely adhered to by the hospitals, the auditors, or the intermediary in the preparation, audit and settlement of the hospitals' Medicare cost reports. The failure to adhere to these principles resulted in (1) costs being overstated and (2) overallocations of costs to inpatient cost centers. In addition, we noted that incomplete or erroneous data had been used in computing the hospitals' reimbursement settlements.

At the time of our review, Georgia Blue Cross had made final settlements with The Macon Hospital and the Medical Center. The Memorial Medical Center's cost report had been audited by the intermediary's auditors, but final settlement had not been made. Georgia Blue Cross officials advised us that the costs we questioned would be considered before making final settlement with the Memorial Medical Center.

We also noted that charges billed by the three hospitals for services of hospital-based physicians exceeded the hospitals' cost for such services because excessive professional component percentages were used to compute that portion of total charges applicable to professional services of the physicians. Further, because excessive reimbursements for services of hospital-based physicians were noted in connection with all three hospital cost reports included in our review, we believe that similar excessive reimbursements may have been made to other hospitals serviced by Georgia Blue Cross.

RECOMMENDATIONS

We recommend that, for the three hospitals we reviewed, the Social Security Administration consider adjusting the hospitals' Medicare cost reports, where appropriate; seeking recoveries accordingly; and making changes in audit procedures where necessary. We also recommend that all Georgia Blue Cross settlements with hospitals be re-examined to determine whether excessive reimbursements have occurred with regard to part B payments for the professional services of hospital-based physicians. Such an examination should be undertaken with a view toward taking recovery action, where appropriate.

CHAPTER 7

SCOPE OF REVIEW

Our review was made at the Georgia Blue Cross office in Columbus, Georgia; the Medical Center, Columbus, Georgia; The Macon Hospital, Macon, Georgia, and the Memorial Medical Center, Savannah, Georgia. We also performed a limited amount of work at the Georgia State Department of Family and Children Services in Atlanta, Georgia.

We reviewed Medicare legislation and related regulations prescribed by the Secretary of Health, Education, and Welfare for the administration of the program. We also examined applicable audit reports and working papers prepared by the intermediary's auditors. In addition, we reviewed pertinent records, reports, and documents and interviewed officials of Georgia Blue Cross and the three hospitals concerned.